

MAINE DEPARTMENT OF LABOR
Bureau of Unemployment Compensation
20 Union Street, P. O. Box 259
Augusta, Maine 04332-0259
(207) 287-3176

APPLICATION FOR TERMINATION OF COVERAGE

1. Business Name	2. Employer Account Number
3. Address (Street and Number) (City or Town) (State) (Zip)	

In Item 4 enter the total amount of reportable wages (see exclusions below) paid each quarter of the preceding calendar year. In item 5 enter in each applicable block the greatest number of individuals, both full and part-time workers, who were employed by you in Maine on the day of the highest employment in each week, for the preceding calendar year. If a corporation, include all your officers who are performing services as well as all other workers. **EXCLUSIONS: All Employers:** Do not include services performed by a student who is participating in a cooperative program of education and occupational training. If a proprietorship, do not include the service performed by an individual in the employ of his son, daughter, spouse, or the service performed by a child under 18 in the employ of his father or mother. Do not include partners in a partnership.

DOMESTIC EMPLOYERS MAY SKIP THIS QUESTION: Do you have a controlling interest in another business with Maine employment, or are you controlled by the controlling interests of another business with Maine employment? If so, list the other Maine Employer Account Number(s) _____: IF NOT, CHECK HERE ☐

Maine Payrolls		Calendar Quarter Ending March 31	Calendar Quarter Ending June 30	Calendar Quarter Ending Sept. 30	Calendar Quarter Ending Dec. 31
Year 19	Regular	\$	\$	\$	\$
	Domestic	\$	\$	\$	\$
	Agricultural	\$	\$	\$	\$

5. AGRICULTURAL EMPLOYMENT

Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	
19																											
	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53

REGULAR EMPLOYMENT

Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	
19																											
	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53

The undersigned hereby affirms that the information given above is true and correct, and hereby makes application for termination of coverage as an employer under the Maine Employment Security Law, such termination to be effective as of January 1, 19__.

Signed	Title	Date
Field Advisor and Examiner		Date

FINDINGS: Your application for termination of coverage is hereby [] ALLOWED DENIED (See letter attached) [] MODIFIED - REASON: _____

Augusta, Maine (date) _____ Signed _____, U. C. Director

INSTRUCTIONS FOR COMPLETING FORM

Application for Termination of Coverage, Form Me. FX-3, should be prepared in triplicate. All items must be completed. Mail original and one copy on or before January 31 of the year the termination is effective, to the Department of Labor, Bureau of Unemployment Compensation, and retain one copy. A duplicate copy of the application will be returned indicating approval or denial.

If the employer has more than one type of employment, all applicable portions of sections 4 and 5 must be completed.